ASHEVILLE Pediatric ASSOCIATES, P.A.

H. Wesley Garbee, M.D.
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Calvin O. Tomkins, M.D.
Ellie M. McCormac, PA-C

Authorization for Disclosure of Health Information

1. I hereby authorize _____ disclose the following

information from the health records of:

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Covering the period(s) of health care from _____ to _____

2. Information to be disclosed:

____ Complete Health Records
____ History & Physical Examination
____ Consultation Reports
____ X-ray Reports
____ Discharge Summary
____ Progress Notes
____ Laboratory tests
____ Other (Please Specify):
_____

I understand that this will include information relating to (check if applicable):
____ Aquired Immunodeficiency Syndrome (AIDS)
____ Human Immunodeficiency Virus (HIV) infection
____ Behavioral health service/psychiatric care
____ Treatment for alcohol and/or drug abuse

3. This information will be disclosed to: _____

For the purpose of _____

4. I understand this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance on this authorization.
Unless otherwise revoked, this authorization will expire on the following date, event or condition.

5. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____ Date: _____

Relationship to Patient: _____

Signature of Witness: _____ Date: _____

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